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CHALENG 2005 Survey: VA Eastern Kansas HCS (VAMC Leavenworth - 677A4)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 195

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 195 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	0	0
Transitional Housing Beds	37	0
Permanent Housing Beds	7	40

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Research grant opportunities for permanent supportive housing.
Transportation	Identify area resources for transportation. Research grant opportunities. Submit grant application to DOL and other resources as appropriate.
Detoxification from substances	Research social detox models and safe home programs. Identify most appropriate model for this community and agency to operate. Research funding opportunities. Apply for grants as appropriate.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **16** **Non-VA staff Participants: 60.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.13	6.0%	3.47
Food	3.44	13.0%	3.80
Clothing	3.25	.0%	3.61
Emergency (immediate) shelter	1.85	19.0%	3.33
Halfway house or transitional living facility	2.88	6.0%	3.07
Long-term, permanent housing	1.87	50.0%	2.49
Detoxification from substances	3.20	31.0%	3.41
Treatment for substance abuse	3.69	.0%	3.55
Services for emotional or psychiatric problems	4.0	6.0%	3.46
Treatment for dual diagnosis	3.7	13.0%	3.30
Family counseling	3.38	.0%	2.99
Medical services	4.19	.0%	3.78
Women's health care	3.57	6.0%	3.23
Help with medication	3.67	.0%	3.46
Drop-in center or day program	3.07	.0%	2.98
AIDS/HIV testing/counseling	3.79	.0%	3.51
TB testing	3.86	.0%	3.71
TB treatment	3.71	.0%	3.57
Hepatitis C testing	3.93	.0%	3.63
Dental care	2.36	13.0%	2.59
Eye care	2.33	6.0%	2.88
Glasses	2.20	6.0%	2.88
VA disability/pension	3.71	.0%	3.40
Welfare payments	3.13	.0%	3.03
SSI/SSD process	3.56	.0%	3.10
Guardianship (financial)	3.33	.0%	2.85
Help managing money	3.33	6.0%	2.87
Job training	3.07	13.0%	3.02
Help with finding a job or getting employment	3.67	.0%	3.14
Help getting needed documents or identification	3.50	6.0%	3.28
Help with transportation	1.79	50.0%	3.02
Education	3.36	.0%	3.00
Child care	2.53	6.0%	2.45
Legal assistance	2.53	19.0%	2.71
Discharge upgrade	3.54	.0%	3.00
Spiritual	3.75	.0%	3.36
Re-entry services for incarcerated veterans	2.71	6.0%	2.72
Elder Healthcare	3.29	13.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.25
Co-location of Services - Services from the VA and your agency provided in one location.	2.29
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.43
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.86
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.75
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.57
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.14
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.86
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.29
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.43
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.83
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.14

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.89
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75

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CHALENG 2005 Survey: VAH Columbia, MO - 543

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 450

2. Estimated Number of Veterans who are Chronically Homeless: 180

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 450 (estimated number of homeless veterans in service area) **x chronically homeless rate (40 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	463	158
Transitional Housing Beds	483	0
Permanent Housing Beds	172	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Increase availability of permanent supportive housing by local CoC partnering with developers and stakeholders. Reassess VA as partner for Shelter Plus Care program to afford more housing options for veterans.
Immediate shelter	Meet with local stakeholders, law enforcement, and developers, share findings on study of establishment of "safe haven" shelter for homeless veterans who may be continuing to use alcohol and/or drugs.
Services for emotional or psychiatric problems	Increase aggressive street and institutionalized outreach to chronically homeless veterans and develop housing plans with each encountered. Continue to work with local CoC to develop database of homeless camps.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **46** **Non-VA staff Participants: 56.8%**
Homeless/Formerly Homeless: **39.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.93	.0%	3.47
Food	3.51	9.0%	3.80
Clothing	3.40	4.0%	3.61
Emergency (immediate) shelter	2.78	22.0%	3.33
Halfway house or transitional living facility	2.96	22.0%	3.07
Long-term, permanent housing	2.47	31.0%	2.49
Detoxification from substances	3.50	7.0%	3.41
Treatment for substance abuse	3.59	11.0%	3.55
Services for emotional or psychiatric problems	3.4	24.0%	3.46
Treatment for dual diagnosis	3.2	11.0%	3.30
Family counseling	2.89	7.0%	2.99
Medical services	3.50	11.0%	3.78
Women's health care	3.10	4.0%	3.23
Help with medication	3.22	7.0%	3.46
Drop-in center or day program	2.73	4.0%	2.98
AIDS/HIV testing/counseling	3.48	.0%	3.51
TB testing	3.49	.0%	3.71
TB treatment	3.41	.0%	3.57
Hepatitis C testing	3.60	.0%	3.63
Dental care	2.11	18.0%	2.59
Eye care	2.33	4.0%	2.88
Glasses	2.24	9.0%	2.88
VA disability/pension	3.42	11.0%	3.40
Welfare payments	2.63	9.0%	3.03
SSI/SSD process	2.98	4.0%	3.10
Guardianship (financial)	2.75	4.0%	2.85
Help managing money	2.58	7.0%	2.87
Job training	2.83	7.0%	3.02
Help with finding a job or getting employment	3.02	11.0%	3.14
Help getting needed documents or identification	3.07	.0%	3.28
Help with transportation	2.74	7.0%	3.02
Education	2.89	.0%	3.00
Child care	2.36	4.0%	2.45
Legal assistance	2.20	11.0%	2.71
Discharge upgrade	2.57	4.0%	3.00
Spiritual	3.34	4.0%	3.36
Re-entry services for incarcerated veterans	2.49	4.0%	2.72
Elder Healthcare	2.86	4.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.46
Co-location of Services - Services from the VA and your agency provided in one location.	1.88
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.71
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.25
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.58
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.79
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.96
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.17
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.71
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.71
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.75

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.36
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.20

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CHALENG 2005 Survey: VAM&ROC Wichita, KS - 452

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 275

2. Estimated Number of Veterans who are Chronically Homeless: 143

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 275 (estimated number of homeless veterans in service area) **x chronically homeless rate (52 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	200	80
Transitional Housing Beds	30	50
Permanent Housing Beds	40	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to be involved with HUD's Super NOFA to bring more dollars into Wichita for long-term, permanent housing. Continue informal partnership with agencies that have Shelter Plus Care vouchers.
Transitional living facility or halfway house	Continue to encourage agencies to apply for VA Grant and Per Diem monies. Also, continue relationship with current GPD agencies. Work with city and county agencies to help educate on need for additional housing in this area.
Dental care	Continue to refer veterans to van homeless dental program by providing 60 days of residential treatment. For other, refer to agency that currently has a dentist working with this population.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **39 Non-VA staff Participants: 61.5%**
Homeless/Formerly Homeless: **12.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.42	3.0%	3.47
Food	3.81	21.0%	3.80
Clothing	3.66	10.0%	3.61
Emergency (immediate) shelter	2.86	15.0%	3.33
Halfway house or transitional living facility	2.36	46.0%	3.07
Long-term, permanent housing	1.76	51.0%	2.49
Detoxification from substances	3.09	3.0%	3.41
Treatment for substance abuse	3.29	15.0%	3.55
Services for emotional or psychiatric problems	3.4	8.0%	3.46
Treatment for dual diagnosis	3.3	3.0%	3.30
Family counseling	2.57	3.0%	2.99
Medical services	3.65	5.0%	3.78
Women's health care	2.91	13.0%	3.23
Help with medication	3.33	.0%	3.46
Drop-in center or day program	3.37	.0%	2.98
AIDS/HIV testing/counseling	3.33	3.0%	3.51
TB testing	3.65	.0%	3.71
TB treatment	3.50	.0%	3.57
Hepatitis C testing	3.38	.0%	3.63
Dental care	1.91	28.0%	2.59
Eye care	2.43	3.0%	2.88
Glasses	2.43	5.0%	2.88
VA disability/pension	3.36	3.0%	3.40
Welfare payments	2.91	.0%	3.03
SSI/SSD process	3.00	3.0%	3.10
Guardianship (financial)	2.67	.0%	2.85
Help managing money	2.56	5.0%	2.87
Job training	2.28	15.0%	3.02
Help with finding a job or getting employment	2.63	13.0%	3.14
Help getting needed documents or identification	2.77	3.0%	3.28
Help with transportation	2.17	15.0%	3.02
Education	2.28	3.0%	3.00
Child care	2.29	.0%	2.45
Legal assistance	2.18	.0%	2.71
Discharge upgrade	2.69	.0%	3.00
Spiritual	3.39	3.0%	3.36
Re-entry services for incarcerated veterans	2.40	5.0%	2.72
Elder Healthcare	2.97	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.44
Co-location of Services - Services from the VA and your agency provided in one location.	1.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.74
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.63
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.42
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.53
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.89
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.58
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.47
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.63
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.74

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.42
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.58

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CHALENG 2005 Survey: VAMC Kansas City, MO - 589

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1800

2. Estimated Number of Veterans who are Chronically Homeless: 630

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1800 (estimated number of homeless veterans in service area) **x chronically homeless rate (35 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	375	5
Transitional Housing Beds	365	20
Permanent Housing Beds	0	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Dental care	Request Dental Services to increase average time homeless veterans must wait for dental appointments. Seek to involve Dental Services staff in annual CHALENG meeting.
Long-term, permanent housing	Partner with community providers who can make these services available. One community partner is already identified and on record as wishing to provide long-term, permanent housing.
Re-entry services for incarcerated veterans	Work with existing community partner to expand services to this population.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **29** **Non-VA staff Participants: 92.9%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.96	.0%	3.47
Food	3.32	13.0%	3.80
Clothing	3.00	9.0%	3.61
Emergency (immediate) shelter	2.96	4.0%	3.33
Halfway house or transitional living facility	2.52	26.0%	3.07
Long-term, permanent housing	2.17	39.0%	2.49
Detoxification from substances	2.85	4.0%	3.41
Treatment for substance abuse	2.96	17.0%	3.55
Services for emotional or psychiatric problems	3.0	22.0%	3.46
Treatment for dual diagnosis	2.8	4.0%	3.30
Family counseling	2.88	.0%	2.99
Medical services	3.35	9.0%	3.78
Women's health care	2.84	.0%	3.23
Help with medication	2.67	9.0%	3.46
Drop-in center or day program	2.88	4.0%	2.98
AIDS/HIV testing/counseling	3.28	.0%	3.51
TB testing	3.28	.0%	3.71
TB treatment	3.19	.0%	3.57
Hepatitis C testing	3.15	.0%	3.63
Dental care	2.12	22.0%	2.59
Eye care	2.32	9.0%	2.88
Glasses	2.17	13.0%	2.88
VA disability/pension	3.24	4.0%	3.40
Welfare payments	2.69	.0%	3.03
SSI/SSD process	2.62	4.0%	3.10
Guardianship (financial)	2.64	.0%	2.85
Help managing money	2.48	9.0%	2.87
Job training	2.80	17.0%	3.02
Help with finding a job or getting employment	2.64	13.0%	3.14
Help getting needed documents or identification	2.73	.0%	3.28
Help with transportation	2.48	13.0%	3.02
Education	2.72	4.0%	3.00
Child care	2.40	.0%	2.45
Legal assistance	2.36	.0%	2.71
Discharge upgrade	2.79	4.0%	3.00
Spiritual	2.88	4.0%	3.36
Re-entry services for incarcerated veterans	2.68	17.0%	2.72
Elder Healthcare	2.64	4.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.95
Co-location of Services - Services from the VA and your agency provided in one location.	1.82
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.70
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.68
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.52
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.36
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.45
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.57
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.64
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.65
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.50

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.24
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.08

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Marion, IL - 609

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 75

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 75 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	125	0
Transitional Housing Beds	223	50
Permanent Housing Beds	1251	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Treatment for substance abuse	VA Medical Center Behavioral Medicine Clinic is proposing expansion of substance abuse services through outpatient care in clinic and Community Based Outpatient Clinics as well as linkages with community resources.
Transportation	Explore linkages with local human services agency that is conducting homeless outreach to also provide transportation.
Re-entry services for incarcerated veterans	This remains a critical topic among CHALENG participants.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **12** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.00	.0%	3.47
Food	3.36	.0%	3.80
Clothing	3.09	.0%	3.61
Emergency (immediate) shelter	2.64	30.0%	3.33
Halfway house or transitional living facility	2.27	20.0%	3.07
Long-term, permanent housing	2.27	40.0%	2.49
Detoxification from substances	2.36	50.0%	3.41
Treatment for substance abuse	2.91	20.0%	3.55
Services for emotional or psychiatric problems	3.2	10.0%	3.46
Treatment for dual diagnosis	2.7	.0%	3.30
Family counseling	3.00	.0%	2.99
Medical services	3.00	.0%	3.78
Women's health care	3.18	.0%	3.23
Help with medication	3.64	.0%	3.46
Drop-in center or day program	2.27	.0%	2.98
AIDS/HIV testing/counseling	2.64	.0%	3.51
TB testing	3.09	.0%	3.71
TB treatment	3.00	.0%	3.57
Hepatitis C testing	2.91	.0%	3.63
Dental care	1.55	20.0%	2.59
Eye care	1.73	10.0%	2.88
Glasses	1.91	10.0%	2.88
VA disability/pension	2.73	.0%	3.40
Welfare payments	2.73	.0%	3.03
SSI/SSD process	2.73	10.0%	3.10
Guardianship (financial)	2.73	.0%	2.85
Help managing money	3.00	.0%	2.87
Job training	2.73	20.0%	3.02
Help with finding a job or getting employment	2.91	30.0%	3.14
Help getting needed documents or identification	2.82	.0%	3.28
Help with transportation	2.82	10.0%	3.02
Education	3.09	.0%	3.00
Child care	2.09	10.0%	2.45
Legal assistance	2.82	10.0%	2.71
Discharge upgrade	2.40	.0%	3.00
Spiritual	3.91	.0%	3.36
Re-entry services for incarcerated veterans	1.73	.0%	2.72
Elder Healthcare	2.82	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.82
Co-location of Services - Services from the VA and your agency provided in one location.	1.30
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.45
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.82
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.27
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.09
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.18
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.18
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.36
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.09
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.27

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.45
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.36

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Poplar Bluff, MO - 647

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 50

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 50 (estimated number of homeless veterans in service area) **x chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	5	10
Transitional Housing Beds	0	5
Permanent Housing Beds	0	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 18

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue efforts to advocate for long-term permanent housing for homeless veterans. Several of our halfway house facilities have, informally, worked with our agency to assist veterans secure long-term housing at their facilities.
Immediate shelter	Continue informal veteran advocacy efforts with our local United Gospel Rescue Mission.
Spiritual	Will discuss need with our local halfway house facilities to ensure that veterans have access to VA chaplain and spiritual growth opportunities.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **14** **Non-VA staff Participants: 78.6%**
Homeless/Formerly Homeless: **7.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	4.00	.0%	3.47
Food	4.18	11.0%	3.80
Clothing	4.09	22.0%	3.61
Emergency (immediate) shelter	4.23	22.0%	3.33
Halfway house or transitional living facility	3.92	11.0%	3.07
Long-term, permanent housing	3.64	44.0%	2.49
Detoxification from substances	4.27	.0%	3.41
Treatment for substance abuse	4.18	.0%	3.55
Services for emotional or psychiatric problems	4.6	11.0%	3.46
Treatment for dual diagnosis	4.2	.0%	3.30
Family counseling	4.45	.0%	2.99
Medical services	4.55	11.0%	3.78
Women's health care	4.09	11.0%	3.23
Help with medication	4.45	.0%	3.46
Drop-in center or day program	3.33	22.0%	2.98
AIDS/HIV testing/counseling	4.18	.0%	3.51
TB testing	4.09	.0%	3.71
TB treatment	4.09	.0%	3.57
Hepatitis C testing	4.27	.0%	3.63
Dental care	3.58	11.0%	2.59
Eye care	3.75	.0%	2.88
Glasses	3.67	.0%	2.88
VA disability/pension	3.92	11.0%	3.40
Welfare payments	3.80	.0%	3.03
SSI/SSD process	4.30	.0%	3.10
Guardianship (financial)	4.00	11.0%	2.85
Help managing money	3.80	11.0%	2.87
Job training	4.00	.0%	3.02
Help with finding a job or getting employment	3.55	11.0%	3.14
Help getting needed documents or identification	3.92	.0%	3.28
Help with transportation	3.45	11.0%	3.02
Education	3.83	.0%	3.00
Child care	3.45	11.0%	2.45
Legal assistance	3.36	.0%	2.71
Discharge upgrade	3.45	.0%	3.00
Spiritual	3.89	33.0%	3.36
Re-entry services for incarcerated veterans	3.42	11.0%	2.72
Elder Healthcare	3.83	11.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.27
Co-location of Services - Services from the VA and your agency provided in one location.	1.55
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.40
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.18
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.09
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.73
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.55
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.73
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.27
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.27
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.36

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.27
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.09

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC St. Louis, MO - 657

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2500

2. Estimated Number of Veterans who are Chronically Homeless: 825

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2500 (estimated number of homeless veterans in service area) **x chronically homeless rate (33 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	765	0
Transitional Housing Beds	750	0
Permanent Housing Beds	200	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Request HUD unites for homeless veterans. Pursue "Habitat for Humanity"-type program development.
Transitional living facility or halfway house	Advocate for sex offenders and other veterans not easily placeable. Encourage agencies to apply for VA Grant and Per Diem funding.
Immediate shelter	Develop Safe Havens for Mentally Ill.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **27** **Non-VA staff Participants: 60.0%**
Homeless/Formerly Homeless: **51.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.72	6.0%	3.47
Food	3.32	6.0%	3.80
Clothing	3.28	.0%	3.61
Emergency (immediate) shelter	3.08	32.0%	3.33
Halfway house or transitional living facility	3.05	56.0%	3.07
Long-term, permanent housing	2.30	74.0%	2.49
Detoxification from substances	3.58	.0%	3.41
Treatment for substance abuse	3.63	26.0%	3.55
Services for emotional or psychiatric problems	3.4	6.0%	3.46
Treatment for dual diagnosis	3.1	6.0%	3.30
Family counseling	2.88	.0%	2.99
Medical services	3.54	6.0%	3.78
Women's health care	2.63	.0%	3.23
Help with medication	3.63	6.0%	3.46
Drop-in center or day program	3.05	6.0%	2.98
AIDS/HIV testing/counseling	3.39	.0%	3.51
TB testing	3.75	.0%	3.71
TB treatment	3.23	.0%	3.57
Hepatitis C testing	3.19	.0%	3.63
Dental care	1.96	21.0%	2.59
Eye care	3.24	6.0%	2.88
Glasses	3.25	.0%	2.88
VA disability/pension	3.30	6.0%	3.40
Welfare payments	2.38	.0%	3.03
SSI/SSD process	2.57	.0%	3.10
Guardianship (financial)	2.33	.0%	2.85
Help managing money	2.67	6.0%	2.87
Job training	2.24	11.0%	3.02
Help with finding a job or getting employment	2.65	11.0%	3.14
Help getting needed documents or identification	2.91	.0%	3.28
Help with transportation	3.00	11.0%	3.02
Education	2.59	11.0%	3.00
Child care	1.95	.0%	2.45
Legal assistance	2.45	.0%	2.71
Discharge upgrade	2.11	.0%	3.00
Spiritual	3.00	.0%	3.36
Re-entry services for incarcerated veterans	2.15	6.0%	2.72
Elder Healthcare	2.47	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.00
Co-location of Services - Services from the VA and your agency provided in one location.	2.20
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.60
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.40
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.45
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.18
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.82
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.64
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.64
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.30
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.40
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.40

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.36
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.00

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Topeka - 677

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 150

2. Estimated Number of Veterans who are Chronically Homeless: 32

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 150 (estimated number of homeless veterans in service area) **x chronically homeless rate (21 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	60	10
Transitional Housing Beds	75	15
Permanent Housing Beds	20	35

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Dental care	The availability of dental care for homeless veterans enrolled in an HCHV program for 60 days has been a help. We will continue to attempt to coordinate a community event utilizing state-wide resources to provide dental services.
Eye Care	We will build on our relationship with local nonprofits to enhance other services for homeless veterans.
Long-term, permanent housing	We have participated in local CoC efforts for more than 10 years. This year's proposed project was to serve chronically homeless, so if successful will have other housing and treatment options.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **30** **Non-VA staff Participants: 70.4%**
Homeless/Formerly Homeless: **6.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.93	.0%	3.47
Food	4.39	8.0%	3.80
Clothing	4.22	.0%	3.61
Emergency (immediate) shelter	4.11	12.0%	3.33
Halfway house or transitional living facility	3.41	20.0%	3.07
Long-term, permanent housing	3.07	32.0%	2.49
Detoxification from substances	3.77	8.0%	3.41
Treatment for substance abuse	3.81	12.0%	3.55
Services for emotional or psychiatric problems	4.0	8.0%	3.46
Treatment for dual diagnosis	3.8	4.0%	3.30
Family counseling	3.24	.0%	2.99
Medical services	4.15	12.0%	3.78
Women's health care	3.62	4.0%	3.23
Help with medication	3.63	8.0%	3.46
Drop-in center or day program	3.69	.0%	2.98
AIDS/HIV testing/counseling	3.76	.0%	3.51
TB testing	3.72	.0%	3.71
TB treatment	3.68	.0%	3.57
Hepatitis C testing	3.76	.0%	3.63
Dental care	2.35	36.0%	2.59
Eye care	2.67	16.0%	2.88
Glasses	2.73	4.0%	2.88
VA disability/pension	3.36	8.0%	3.40
Welfare payments	3.37	.0%	3.03
SSI/SSD process	3.12	20.0%	3.10
Guardianship (financial)	2.96	.0%	2.85
Help managing money	2.85	24.0%	2.87
Job training	3.22	4.0%	3.02
Help with finding a job or getting employment	3.30	8.0%	3.14
Help getting needed documents or identification	3.19	4.0%	3.28
Help with transportation	3.08	16.0%	3.02
Education	3.24	12.0%	3.00
Child care	2.52	12.0%	2.45
Legal assistance	3.00	4.0%	2.71
Discharge upgrade	2.86	.0%	3.00
Spiritual	3.64	.0%	3.36
Re-entry services for incarcerated veterans	2.70	4.0%	2.72
Elder Healthcare	2.88	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.12
Co-location of Services - Services from the VA and your agency provided in one location.	1.59
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.88
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.81
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.88
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.76
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.56
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.06
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.94
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.94
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.06

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.60